



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

ORTHOTEXAS PHYSICIANS AND SURGEONS

**Respondent Name**

DALLAS COUNTY

**MFDR Tracking Number**

M4-16-2127-01

**Carrier's Austin Representative**

Box Number 44

**MFDR Date Received**

MARCH 25, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "For this date of service our office was informed there is no claim on file for this date of service. We filed this claim electronically. I have attached the Availity report as proof of timely filing...Per the clearing house report DOS 9/15/2015 was translated on 9/22/2015 and mailed to the payer on 9/24/2015. All of these dates fall within the 95 day timely filing deadline.."

**Amount in Dispute:** \$1,329.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Even now at MFDR, the Requestor has still not presented evidence that the initial billing was timely sent to the Respondent. There is no bill with a printed date within 95 days of the date of service. The bill and all other documentation presented by the Requestor at MFDR all note a date of February 10, 2016. The Requestor appears to be relying on a claim history printout to prove the initial billing was timely sent. This printout only shows something was printed to be mailed. This is not evidence of timely submission and the Respondent did not receive any bill within 95 days of the date of service. If the bill was submitted electronically there would be evidence of that. If the bill was timely printed and mailed there should be a copy of the billing with a date prior to February 10, 2016."

**Response Submitted by:** White Espey, PLLC

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2015	CPT Code 99203 Office Visit	\$250.00	\$0.00
	CPT Code 99080-73 Work Status Report	\$15.00	\$0.00
	CPT Code 95886-KX (X 2) Needle EMG	\$434.00	\$0.00
	CPT Code 95912-59-KX Nerve Conduction Studies	\$630.00	\$0.00
TOTAL		\$1,329.00	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for healthcare providers submitting medical bills.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
6. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
7. The services in dispute were reduced / denied by the respondent with the following reason codes:
  - 29-The time limit for filing has expired.
  - Per rule 133.20; a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided.

### **Issues**

1. Did the requestor support position that the disputed bills were submitted timely?
2. Does the documentation support billing code 99203?
3. Does the documentation support billing code 95886?
4. Does the documentation support billing code 95912?
5. Does the documentation support billing code 99080-73?

### **Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing has expired."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green card to support the disputed bill was sent to the respondent within the 95 days deadline.

The Division finds that the requestor supported its position that the disputed bill was submitted timely on September 24, 2015 to WorkCompEDI in accordance with Texas Labor Code §408.027(a); therefore, the respondent's denial based upon reason code "29" is not supported.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99203 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision

making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family."

A review of the submitted medical report does not support the documentation requirement which require the 3 key components for code 99203; therefore, reimbursement is not recommended.

3. CPT code 95886 is defined as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)."

A review of the submitted medical report does not support billing code 95886; therefore, reimbursement is not recommended.

4. CPT code 95912 is defined as "Nerve conduction studies; 11-12 studies."

A review of the submitted medical report does not support billing code 95912; therefore, reimbursement is not recommended.

5. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions."

A review of the submitted documentation finds the requestor did not support billing code 99080-73 in accordance with 28 Texas Administrative Code §129.5. As a result, reimbursement is not recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

04/15/2016  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**